A man receives care at Mission of Mercy Clinic in Brunswick, Maryland—one of 8,000 nonprofit, community-based health facilities collectively serving 21 million people annually in the U.S.

THE STATE of THE SAFETY NET 2012
The Economic Crisis and America’s Nonprofit Clinics and Health Centers
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8,000 HEALTH FACILITIES,
50 STATES,
21 MILLION PATIENTS
1/3 LACK INSURANCE,
71% BELOW POVERTY LEVEL
“State cuts and the current economic situation have increased the need for our services. We are trying our best to do more with less.”

—RYAN MESSINGER, ASSISTANT DIRECTOR, HEALTHNET OF ROCK COUNTY, INC., JANESVILLE, WISCONSIN
This report summarizes the results of the largest national survey conducted in 2012 of U.S. nonprofit community-based health clinics, Federally Qualified Health Centers (FQHCs), and free clinics as well as the most current available national data (from 2006-2010) about patients and activities at America’s FQHCs.

The conditions, perceptions, and trends recorded at these nonprofit, community-based healthcare facilities about how they and their patients are faring in 2012 reflects what a broad and diverse cross-section of healthcare providers believes to be the state of the nonprofit healthcare safety net in the U.S.

This is What a Broad Cross-section of Providers Believes to Be the State of Nonprofit Health Care.

This is a snapshot of the efforts by a wide array of America’s nonprofit healthcare institutions to serve the most vulnerable people during an ongoing period of intense economic stress. This report takes no position on the causes of the recession. Instead, it illuminates some of the many ways in which people throughout the U.S. — particularly those with low incomes and without health insurance — depend daily upon the safety net, including during emergencies.

The private, nonprofit community-based health facilities that are the subject of this report operate independently.
Direct Relief estimates they run over 8,000 healthcare sites in all 50 states and provide comprehensive health care and referral services to over 21 million people, approximately 37.5 percent of whom lack health insurance and 71.8 percent have incomes at or below the Federal Poverty Level (FPL — $23,050 per year for a family of four).

Because these facilities and their staffs provide care regardless of a person’s insurance status, income, or ability to pay, they are a large, essential component of the healthcare safety net in the U.S. for people who otherwise have limited options to access care they need. This safety-net role extends to emergency situations, during which the low-income persons whom the facilities disproportionately serve are among the most vulnerable. There are also other facilities, particularly hospital emergency rooms, and a wide array of programs run by government and other nonprofit and religious institutions that provide essential health and social services in the country.

This report also contains two case studies that highlight why the term “safety net” is apt in describing these facilities’ roles on a daily basis and during emergencies. The first looks at Detroit, Michigan, a community hard hit by the

As this report was finalized, the U.S. Supreme Court issued its highly anticipated decision on The Patient Protection and Affordable Care Act, which was enacted into law in 2010. The Court upheld the constitutionality of the so-called “individual mandate” relating to the purchase of private health insurance. However, the ruling also permitted states to opt out of the expanded Medicaid provisions in the law, which were expected to cover 17 million people.

The Court’s decision allows attention to be focused on how the law will be implemented and its ultimate effects, about which significant uncertainty unavoidably remains. However, the nonprofit safety-net facilities that are the subject of this report are certain to continue to play a critical role in providing access to comprehensive health care for people with low incomes, regardless of their insurance status. These facilities existed before the law was enacted, are deeply embedded within thousands of communities across the U.S., and are providing access and services to millions of people.

Moreover, these facilities specialize in and have achieved demonstrable success on many of the issues about which broad consensus exists — expanded access to affordable, high-quality services and increased emphasis on preventive and primary care. If these facilities did not exist, they would have to be invented to accomplish these goals. The examination of their circumstances and trends reflects how the healthcare needs of people in the United States, particularly those with low incomes, are being met. It will also be a way to gauge progress against the broader consensus policy goals of access to affordable, high-quality health care services for all people.
The State of the Safety Net 2012 // Introduction

The U.S. has 5,750 hospitals and more than 8,000 nonprofit clinics.

Introduction >>

These facilities are a large, essential component of the healthcare safety net in the U.S. for people who otherwise have limited options to access care they need.

...recession, where clinics have seen a 10 percent rise in patient volume since 2008. The other examines the case of Joplin, Missouri, where nonprofit clinics and health centers helped care for thousands of people when the main hospital was destroyed by a devastating tornado.

Direct Relief’s extensive day-to-day interaction with America’s safety-net facilities generates significant, unique data on a national scale and a perspective that is otherwise unavailable.

Direct Relief USA is the only U.S. nonprofit licensed to distribute prescription medications in all 50 states. It is a private charitable effort to help people who lack financial means obtain access to the care and medications they need through a nationwide network of locally run, community-based nonprofit health centers and clinics — on an ongoing basis and during emergencies. Direct Relief identifies gaps and provides donations of medications and health supplies for clinic and health-center patients with low incomes and no or inadequate insurance.

Barry Wilson, Chief Pharmacy Officer of Family Care Health Centers in St. Louis, Missouri, restocks pharmacy shelves.
TERMINOLOGY //

> **Direct Relief Partner** – a community clinic, Federally Qualified Health Center, or free or charitable clinic that was vetted and approved to be part of the Direct Relief Partner Network.

> **Direct Relief Partner Network** – the network of more than 1,000 community clinics, Federally Qualified Health Centers, or free and charitable clinics that Direct Relief currently supports with donations of free medicine and medical supplies.

> **Federal Poverty Level (FPL)** – the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter, and other necessities as determined by the Department of Health and Human Services. FPL varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines.

> **Medicaid** – a U.S. government program—financed by federal, state, and local funds—that provides health coverage for lower-income people, families and children, the elderly, and people with disabilities.

> **Safety Net** – the network of nonprofit provider agencies that deliver health services to vulnerable populations experiencing financial, cultural, linguistic, geographic, or other obstacles to accessing adequate health care. The nation’s healthcare safety net includes more than 8,000 clinical sites providing comprehensive, culturally-competent health services to more than 21 million people regardless of their ability to pay.

**TYPES OF SAFETY-NET FACILITIES**

> **Community Clinic** – a nonprofit provider agency that treats anyone regardless of ability to pay, but generally charges patients on a sliding fee scale.

> **Federally Qualified Health Center (FQHC)** – public and private nonprofit healthcare providers located in medically underserved areas that treat anyone regardless of ability to pay, and meet certain federal criteria under the Health Center Consolidation Act (Section 330 of the Public Health Service Act). There were 1,124 FQHCs operating almost 7,000 sites in 2010 that treated 19.5 million people across the United States, of whom 7.3 million lacked health insurance.

> **Free Clinic** – a nonprofit, typically volunteer-based provider facility that treats anyone regardless of ability to pay, that typically treats patients free of charge, or with a nominal donation for services. An estimated 1,000 free clinics operate across the United States.

> **Look-Alike** – an organization that meets the eligibility requirements of the Section 330 of the Public Health Service Act, but does not receive federal grant funding. Look-Alikes receive many of the same benefits as FQHCs, including enhanced Medicare and Medicaid reimbursement, and eligibility to purchase prescription and non-prescription medications at a reduced rate, among other benefits.
"We are seeing much sicker and more complex patients. As a result, the level of care provided in this clinic has changed. The community health centers are becoming maxed out with uninsured patients."

— JANICE ERTL, CLINIC DIRECTOR, ST. VINCENT DE PAUL CLINIC, PHOENIX, ARIZONA

THE PROVIDERS

Direct Relief’s 2012 Nationwide Partner Outlook Survey
Assessing current conditions and trends across America’s nonprofit safety-net clinics and health centers presents significant challenges. These facilities operate independently within their communities and have different reporting requirements. Even where one can collect standard information, at the more than 1,000 Federally Qualified Health Centers [and FQHC Look-Alikes] nationwide, such information is reported on an annual basis that enables only retrospective analysis after it is made available the following year.

As economic struggles continued into early 2012, Direct Relief surveyed its nationwide partner network of nonprofit safety-net community clinics and health centers about their current circumstances, trends, and perceptions about near-term prospects for the remainder of 2012. The survey was distributed to 1,092 clinic and health center partners in all 50 states. Direct Relief received 546 responses (50 percent response rate) from clinics in 49 states and Washington D.C.

Overall, the survey results reflected continued pressure in providing services and concern among nonprofit providers about their ability to care for an increasing number of patients in an increasingly challenging environment. Seventy-nine percent of respondents indicated that they saw more patients in 2011, and 86 percent expected an increase in the number of patients without health insurance during 2012. When asked about their overall outlook for the remainder of 2012 with respect to funding and patient trends, 83 percent of respondents indicated their belief that the environment would be more challenging.

In a commercial enterprise, a spike in demand would be expected to generate either higher prices or expanded supply (or both). Neither occurs when the demand is for health services among patients unable to pay. Because nonprofit facilities’ own financial constraints can result in reduced hours, staffing, and overall capacity to see patients, the survey also inquired about facilities’ staffing levels and operating hours to gauge the relation between capacity in the safety net and demands upon it.

Overall, the survey found that facilities had expanded capacity as measured by increased staffing (56 percent) and, to a lesser degree, by operating hours (41 percent), although the adequacy of such increases against demand was not examined. In contrast, among the facilities that reported a decrease in staffing (16 percent) a majority indicated that it was due to a decrease in funding.

The following charts show the responses to the survey.

**Did Your Facility See an Increase, Decrease, or No Change in the Total Number of Patients in 2011?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase</td>
<td>79%</td>
</tr>
<tr>
<td>About the same</td>
<td>15%</td>
</tr>
<tr>
<td>Decrease</td>
<td>6%</td>
</tr>
</tbody>
</table>

“Many of our formerly insured patients now have little or no health coverage. This means more demand and fewer services available. As these patients will not receive day-to-day well-care, there will be a corresponding increase in primary health care needs. This is taxing community clinics in California.”

— SUSAN EDDONDS, PHARMACY PROGRAM MANAGER, LIFELONG MEDICAL CARE, BERKELEY, CALIFORNIA
**DID YOUR FACILITY EXPERIENCE AN INCREASE, DECREASE, OR NO CHANGE IN THE HOURS OF OPERATION?**

<table>
<thead>
<tr>
<th>Decrease</th>
<th>Increase</th>
<th>Same</th>
</tr>
</thead>
<tbody>
<tr>
<td>3%</td>
<td>41%</td>
<td>56%</td>
</tr>
</tbody>
</table>

- **3% Decrease**: Fewer patients in need of service
- **41% Increase**: If you experienced a decrease in hours of operation, why was that the case?
- **56% Same**: About the same

**“We are totally funded by grants and donations. These sources are becoming more difficult to find and obtain and we are really struggling to keep the doors open.”**
— LINDA TAYLOR, CLINICAL MANAGER, COWLITZ FREE MEDICAL CLINIC, LONGVIEW, WASHINGTON

**DID YOUR FACILITY EXPERIENCE AN INCREASE, DECREASE, OR NO CHANGE IN OVERALL STAFFING LEVELS?**

<table>
<thead>
<tr>
<th>Decrease</th>
<th>Increase</th>
<th>No Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>16%</td>
<td>28%</td>
<td>56%</td>
</tr>
</tbody>
</table>

- **16% Decrease**: If you experienced a decrease in staff, why was that the case?
- **28% No Change**: If you experienced a decrease in hours of operation, why was that the case?
- **56% Increase**: About the same

**“We continue to experience an increase in uninsured patients — several large companies have closed here. We also reduced staff due to cuts in state funding.”**
— MARY DAVIS, DIRECTOR OF NURSING, COMMUNITY HEALTH SERVICE AGENCY, GREENVILLE, TEXAS
IN 2012, DO YOU EXPECT THAT THE NUMBER OF PATIENTS WITHOUT HEALTH INSURANCE WILL INCREASE, DECREASE, OR STAY THE SAME?

- 86% INCREASE
- 12% STAY THE SAME
- 2% DECREASE

“We are seeing more uninsured and it’s really taking a toll on our funding from any source. We are not sure how we are going to be able to balance things and keep up with the demand from the uninsured.”
— TRACEY CAUSEY, CEO, VERNON J. HARRIS EAST END COMMUNITY HEALTH CENTER, RICHMOND, VIRGINIA

BASED ON FUNDING AND PATIENT TRENDS, DO YOU THINK 2012 WILL BE EASIER, MORE CHALLENGING, OR ABOUT THE SAME COMPARED WITH 2011?

- 83% MORE CHALLENGING
- 13% ABOUT THE SAME
- 4% EASIER

“Due to continued lay-offs, we expect to see a great increase in our patients. Our donations have also taken a large drop. People who in the past have been donors are now likely to become patients.”
— DEBBIE LEAKEY, LPN, GOOD SAMARITAN CLINIC, FORT SMITH, ARKANSAS
Most patients live at or below the federal poverty level.

Margaret Molloy

Dr. John Hoh, Medical Director of Asian Pacific Health Care Ventures in Los Angeles, California, examines a patient.

THE PATIENTS
People Being Cared for by the Safety Net
The following provides an overview of patient information from 2010 for the nearly 20 million people treated annually at the nation’s Federally Qualified Health Centers (FQHCs) and Look-Alikes.

→ 19.5 million total patients served

→ 7.3 million patients (37.5%) lacked health insurance

→ The vast majority (71.8%) of patients with known income levels live at 100% or below the federal poverty level (FPL) — in 2010, that was $10,830 for an individual and $22,050 for a family of four.

→ 131,660 total staff (full time equivalents)

The following charts show demographic information on patients at FQHCs in 2010, and what has changed compared to previous years.

**TOTAL FQHC PATIENTS, KNOWN INCOME LEVELS // 2006-2010**

From 2006-2010, the number of patients seen at FQHCs increased by 29.5%. In the same period, the percentage of patients with incomes below 100% of the federal poverty level (FPL) dipped slightly from 2006-2008 (70.7% → 69.9%) and increased from 2008-2010 (69.9% → 71.8%).

**KNOWN INCOME LEVEL OF FQHC PATIENTS // 2010**

Total patients = 14.9 million

- 71.8% AT OR BELOW 100% OF FEDERAL POVERTY LEVEL (FPL)
- 14.4% 101-150% OF FPL
- 7.2% OVER 200% OF FPL
- 6.5% 151-200% OF FPL
INSURANCE SOURCE OF FQHC PATIENTS // 2010
Total patients = 19.5 million

38.5% MEDICAID
37.5% UNINSURED
13.9% PRIVATE
7.5% MEDICARE
2.5% PUBLIC

TOTAL PATIENTS, INSURANCE SOURCE // 2006-2010
FQHC patients’ sources of insurance shifted slightly from 2006-2010, but 2010 was the first year that Medicaid patients exceeded uninsured patients in total numbers and as a percentage of the overall patient population.

“We are seeing people who are sicker than ever and do not know what to do about it. They are new to the system. They have lost their job, their insurance, their home, their car, and filed for bankruptcy. They have never been in this shape before.”

— TRACY THOMPSON, EXECUTIVE DIRECTOR, MERCY HEALTH CENTER, ATHENS, GEORGIA
A 2010 SNAPSHOT OF GENDER, RACE, AND ETHNICITY AT FQHCS

→ There were almost twice as many women seen between the ages of 25-44 than men (3.4 million versus 1.9 million).

→ Those aged 50-69 are the fastest growing group as a proportion of the whole, yet children are still the largest overall proportion.

→ The FQHC population is 35% Hispanic/Latino while, according to the 2010 U.S. Census, nationally only 16% of the U.S. population is Hispanic/Latino.
More people with chronic conditions are being cared for at nonprofit health facilities.

THE CONDITIONS
Chronic Illness and Insurance Status

Margaret Molloy
South Central Family Health Center, Los Angeles, California
An analysis of the 2010 data shows the continuing trend of an increase in the number of patients with chronic health conditions. This is significant not only because these conditions result in a large percentage of total services provided [two diagnoses, diabetes mellitus and hypertension, account for 10 percent of all visits nationwide], but they require more services over a longer period of time, thereby adding disproportionate stress on staffing and budgets.

Direct Relief analyzed the rate of change in chronic diseases facing clinics and health centers: heart disease, asthma, diabetes, and hypertension. In an analysis from 2006 to 2010, the rates of these conditions noted in red are increasing at a rate higher than that of the FQHC patient population as a whole. This outpacing creates further resource concerns as health centers are not only treating more patients annually, but more patients with chronic conditions.
**DIABETES AMONG FQHCs AND DIRECT RELIEF NETWORK**

The rate of patients seen at FQHCs for diabetes as their primary diagnosis has remained flat nationally at just over six percent since 2007. Several states — including Oregon, Nevada, and Virginia — have seen their rates increase by between one percent and three percent annually during that time (Figures 1 and 2). While rates may be increasing in some states, it is not all negative news. In the case of many states, increased rates of diagnosis and treatment of diabetes have been accompanied by improved quality and effectiveness of care, indicated by improved control of blood sugar levels (HbA1c — Figure 3). In Virginia, for instance between 2009 and 2010, the only two years for which we have reliable data, the number of patients with HbA1c counts exceeding nine (indicating dangerously high blood sugar) declined by six percent even as their rate of persons diagnosed and treated for diabetes increased from eight percent to 11 percent.

**FINDINGS FROM DIRECT RELIEF SURVEYS**

Critical gaps remain in understanding the changing relationships between chronic illness, poverty, and health insurance. Because the best publicly available data on FQHCs — the Health Resources and Services Administration’s (HRSA), Uniform Data System (UDS) — does not include cross-tabulated patient data, Direct Relief has attempted to understand these relationships through routine surveys of its own partner network. In a survey on changes in numbers of patients with diabetes without health insurance between 2009 and 2010, Direct Relief received responses from 432 clinics and health centers in its partner network. Roughly half of the responses were from FQHCs and Look-Alikes and one-third were from free clinics. While the findings on health insurance were consistent with the overall FQHC reporting, which indicated little to no change in the proportion of uninsured, there was evidence that patients with diabetes who lacked health insurance were being seen at a significantly higher rate than increases in people without insurance and in the patient population as a whole.

Direct Relief’s partners reported seeing a 5.29 percent increase in total patients and only a 0.76 percent increase in patients without health insurance. They reported a 6.89 percent increase in patients with diabetes who lacked health insurance. This finding tends to suggest that the patients without insurance are more likely than other groups of patients to present with diabetes, which pose financial strains for individuals and clinics alike given the high costs of chronic medications and long-term healthcare.

**Figure 1**

**CHANGE IN DIABETES DIAGNOSES AT FQHCs BY STATE // 2007-2010**

**Figure 2**

**STATES WITH THE LARGEST INCREASES AND DECREASES IN THE RATES OF DIABETES DIAGNOSES AT FQHCs // 2007-2010**

**Figure 3**

**CONTROLLING DIABETES: CHANGE IN PATIENTS WITH HbA1c% > 9 AT FQHCs BY STATE //2009-2010**
INSURANCE & MEDICAID TRENDS AT FQHCs

The most salient trend in health insurance at FQHCs from 2007 to 2010 was the rapid increase in the proportion of patients on Medicaid, above and beyond those reported to be uninsured. Between 2007 and 2010 the rate of people without insurance being seen at FQHCs actually decreased two percent nationally, from 40 percent to 38 percent. The total patient population did increase, so despite the percentage drop the total number of people without insurance being seen at FQHCs increased during this time period. At the same time though, the rate of persons on Medicaid increased substantially, from 35 percent to 39 percent. In 2010, Medicaid patients exceeded the rate of uninsured patients for the first time since UDS data has been collected. This trend in insurance payments has been consistent annually and not confined to any particular section of the country. Whereas all but five states saw either no change or an increase in their rate of Medicaid patients, a total of 33 states either saw no change or a decrease in their rate of uninsured patients.
Detroit’s unemployment rate nearly doubled, from 14% to a devastating rate of nearly 28%. 
EXPANDING CARE IN A RECESSION

CASE STUDY // DETROIT, MI

The issues faced by people in Detroit, Michigan have been mounting for decades. According to the U.S. Census and the Bureau of Labor Statistics, the city’s jobs-base shrunk, property values plunged, social services were cut back, and hundreds of thousands of people moved away. Based on the American Community Survey five-year estimate from 2006 to 2010, nearly 20 percent of all households in Detroit had annual incomes less than $10,000. These long-term stresses made Detroit more vulnerable than most U.S. cities to the economic turbulence of 2008. From January 2008 to July 2009, Detroit’s official unemployment rate nearly doubled, from 14 percent to a devastating rate of nearly 28 percent. Since then, conditions have improved, but at a pace which has failed to restore pre-2008 levels of employment, growth, or funding for social services.

Detroit’s nonprofit healthcare safety net — woven from a mix of FQHCs, community clinics, and free clinics — plays a central role in ensuring availability of comprehensive healthcare services for the people who are poor and lack insurance, particularly given that Detroit has no public hospital and suffered a steep decline in health service provision by the department of public health since 2008 due to municipal budget cuts.

In 2010, the most recent year for which there is reliable data, safety net medical providers operated a total of 14 clinical service delivery sites throughout the city of Detroit. Those sites served a patient community of 51,672 individuals, up 10 percent from roughly 46,600 since 2008. The safety net patient community has grown while the population of the city as a whole has shrunk. Between 2008 and 2010 the proportion of Detroit’s total population being treated at safety net institutions increased by one percent overall, from six percent to seven percent. Among that patient community in 2010, roughly 61 percent reported incomes at or below 200 percent of the federal poverty line and 59 percent reported having no health insurance. At least 20 percent of patients seen at safety net institutions in Detroit were diagnosed primarily for hypertension, eight percent for diabetes, and three percent for asthma.
The State of Detroit’s Safety Net

Motor City clinic responses to Direct Relief’s 2012 Partner Outlook Survey

→ Three out of four reported an expectation that their overall operating environment through 2012 would be more challenging; one reported no expected change.
→ Three out of four reported an increase in patients; one saw no change in the number of patients.
→ Two reported that they expected to see an increase in patients without health insurance; two expected uninsured rates would stay about the same.
→ One clinic saw an increase in hours of operation; the others reported no change to their hours.
→ Two clinics reported an increase in staffing, one saw no change, and one saw a decrease.

Mark Kirsch
Pharmacist, Community Health and Social Services

“As of February 2012, the City of Detroit has closed down the health department pharmacy and adult medical services. We anticipate at least 6,000 new pharmacy patients.”

Pharmacist Mark Kirsch works in the pharmacy at Community Health and Social Services in Detroit, Michigan.
Clinics and health centers are located in medically underserved neighborhoods throughout the country. In Detroit, 14 clinics and health centers treat more than 50,000 people. Many of these patients live in communities where nearly a quarter of households earn less than $10,000 annually.
ROLE OF THE
SAFETY NET DURING
EMERGENCIES

CASE STUDY // JOPLIN, MO TORNADO

Late in the hot and humid Sunday afternoon of May 22, 2011, the city of Joplin, Missouri was struck by a massive EF5 “supercell” tornado. Wind speeds exceeded 200 miles per hour. Within hours, roughly 75 percent of the city was damaged, 7,000 homes were destroyed, and 161 persons killed. St. John’s Regional Hospital, the area’s primary medical center, was among the many buildings crippled by the tragedy. Storm survivors turned to community health centers and clinics for both acute and chronic medical care in the wake of the disaster.

Safety-net clinics are a primary source of healthcare for low-income, uninsured families in their communities. Every day, they operate as a crucial component of the U.S. health system as they provide care for all patients regardless of their ability to pay. Their role becomes even more critical during times of emergency when resources are strained and there is greater need with limited points of care. Hospitals can be quickly overwhelmed, as surge capacity is limited, clinics and health centers, often working with local public health departments, serve as an essential resource.

Located in the heart of tornado activity, ACCESS Family Care and the Community Health Clinic of Joplin normally treat over 10 percent of Joplin’s total population, including much higher proportions of patients who are low-income and uninsured. In the hours after the tornado, ACCESS Family Care set up temporary care sites and distributed wound-care supplies, medications, and...
Patients seen since the storm last year continue to increase while funding opportunities dwindle and grants decrease due to the economy.

Tornado survivors turn to Joplin clinics for care. While funding opportunities dwindle and grants decrease due to the economy, tornado survivors turn to Joplin clinics for care. Direct Relief bolstered its previously existing partnerships with these clinics, both of which Direct Relief has supported since 2009. To support the ACCESS’s efforts, Direct Relief provided essential medical supplies and two grants totaling close to $50,000 to assist in expanding its services in the community. Direct Relief also supported ACCESS with donations of medical material aid valued at $880,800. These donations helped enable ACCESS to continue to treat people in the immediate aftermath as well as through their sustained recovery efforts.

Post-disaster, the need for medical support continues. Direct Relief donated tetanus vaccines to the Community Health Clinic of Joplin to distribute to community members involved in debris cleanup. In addition, many people suffered from depression and post-traumatic stress disorder following the disaster. To address the mental health needs of uninsured patients, Direct Relief provided a $32,000 grant to the Community Health Clinic of Joplin. Direct Relief has worked with the Community Health Clinic of Joplin since August 2009 to provide donations valued at $154,300.

The Community Health Clinic’s Executive Director, Barbara Bitton, reported that in each month since the tornado struck, the clinic continues to see 200 patients affected by the disaster. According to Ms. Bitton, the total number of patients since the storm last year continues to increase while funding opportunities dwindle and grants decrease due to the economy. Ms. Bitton doesn’t expect the economic impact on their clinic to change. As Joplin recovers, it is clear that the work of nonprofit providers such as ACCESS Family Care and the Community Clinic of Joplin were essential in treating thousands of people in need.
Direct Relief USA and the Safety Net

Reaching 4 million patients without health insurance.
Since 1948, Direct Relief has provided humanitarian assistance to improve the health and quality of life of people affected by poverty and disasters throughout the world by providing essential material resources—medicine, medical supplies, and basic equipment.

Direct Relief USA is the nation’s leading nonprofit provider of donated medicines to community clinics, free clinics, and community health centers for low-income patients without health insurance. It operates the largest charitable medicines program of its kind, and is the only nonprofit licensed to distribute medicine in all 50 states. Since 2004, Direct Relief USA has delivered more than $300 million (wholesale) in medical resources to more than 1,000 nonprofit clinic and health center corporations.

Direct Relief is recognized for its fiscal strength, accountability and efficiency, and consistently achieves top rankings from Forbes, Charity Navigator (including “Top Charity” and “4-Stars”), the Better Business Bureau, and Consumers Digest. In 2011, Forbes rated Direct Relief “100% efficient” and “[Among the] 20 most efficient large U.S. charities.”

Networking 1,000 Nonprofit Clinic and Health Center Corporations—The Largest Charitable Medicines Program in the U.S.

Direct Relief’s Clinic and Health Center Partner Network

11 million patients

The Only Nonprofit Licensed to Distribute Prescription Medicine in All 50 States, and the Only Nonprofit That Is a Verified Accredited Wholesale Distributor by the National Association of Boards of Pharmacy.
This report’s analysis is based on Direct Relief’s survey and program data from its interactions with more than 1,000 nonprofit clinics and health centers and on federal data from the Uniform Data System (UDS) from the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services.

The effort was greatly enabled and significantly enhanced by extensive pro-bono support from Palantir in the form of its powerful analytic computing platform and its talented staff.

Direct Relief also would like to thank its other technology partners who donated software and assistance, Esri, SAP, and Simpler Systems.

Direct Relief’s surveys of its partner network were performed through the Direct Relief Network, Direct Relief’s SAP Enterprise Portal, which in addition to data collection, serves as an ordering platform for donated medicine, medical supplies, and equipment. Information from respondents was analyzed with federally audited data from UDS and validated to ensure accuracy.

Direct Relief extends special thanks to the National Association of Community Health Centers (nachc.com) and The National Association of Free and Charitable Clinics (nafccclinics.org) for their assistance in helping to connect Direct Relief with its respective members.
METHODOLOGIES // DATA SOURCES

HEALTH RESOURCES AND SERVICES ADMINISTRATION
Uniform Data System
The information presented here applies to those entities from which the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) collects data through the Uniform Data System (UDS). These are grantees of the following HRSA primary care programs: Community Health Centers, Health Care for the Homeless, and Public Housing Primary Care providers. Grantees can be found in all 50 states, the District of Columbia, and U.S. territories. The reported data should not be extrapolated to any other population as it is representative only of those individuals who utilize services of FQHC grantees.

Please note that rates of diagnoses, insurance levels, demographics, etc. are descriptive measurements to provide context and are not intended for the sake of population-level analysis or comparison with institutions that are nonprofit safety-net health centers and clinics. For example, a particular health center might show that a high percentage of its patient population consists of homeless individuals. This does not necessarily mean that the area in which it operates has an exceptionally high rate of homelessness. Rather, the health center may have specific programs and outreach aimed at bringing health care to homeless individuals. Such a program therefore would skew the facility’s patient population numbers not only away from the norm of its service area, but also from levels seen at FQHCs without such programs. Likewise, disease diagnosis rates recorded at these institutions should not be mistaken for disease prevalence rates among the area’s general population. It should also be noted, however, that all FQHCs are located by law in areas that are deemed by the federal government to be medically underserved.

2012 DIRECT RELIEF PARTNER SURVEY DATA
Direct Relief Partner Outlook Survey
The survey was transmitted electronically to all FQHCs, community clinics, and free clinics in the U.S. for which Direct Relief had contact information in 2012. The survey was distributed to 1,092 clinic and health center partners in all 50 states. Direct Relief received 546 responses from clinics in 49 states and Washington D.C. Survey respondents were not preselected. The purpose of the survey was to gauge overall mood and attitudes among Direct Relief’s partners about their environment in 2011 and what they anticipate 2012 will look like.

Diabetes Data
The survey was transmitted electronically in 2011 to all FQHCs, community clinics, and free clinics in the U.S. for which Direct Relief had contact information and in partnership with the National Association of Community Health Centers and The National Association of Free and Charitable Clinics. Survey respondents were not preselected. However, survey data cannot be described as truly random as this survey was conducted in conjunction with an offer of donated needles and syringes from BD aimed at ameliorating the conditions for low-income and uninsured patients with diabetes at safety-net facilities. Therefore, inference to the entire U.S. safety-net clinic and health center population should be approached accordingly. Sources of sampling bias inhibiting inferential analysis are such factors as relative need for the product and prior frequency of response to Direct Relief offers of charitable medications and supplies. Nevertheless, the size and scope of the clinical sample of the reported patient population lend significant credence to the descriptive value to this data as a snapshot for critical patient trends.

Four-hundred thirty-two clinics and health centers responded to the survey, resulting in the delivery of five million needles and syringes. These 432 respondents, including a significant number of providers representing multiple clinical service delivery sites, spanned 48 states.